CULTURAL COMPETENCE IN MENTAL HEALTHCARE AMONGST CENTRAL AMERICAN MIGRANTS.

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DEDICATION

"For I know the thoughts that I think toward you, saith the LORD, thoughts of peace, and not of evil, to give you an expected end" (Jeremiah 29 vs 11). First, this thesis is dedicated to the delectable creator of the universe, God Almighty, for his enormous gift of wisdom, knowledge and understanding throughout this process. Without him being the integration point of this milestone, this thesis would not have been executed. There are several people without whom we would not have participated in this thesis and to whom we are indebted. To our parents, (Mr. & Mrs. Lawal) and (Mr. and Mrs. Benson Omoigui) and our siblings (Quam and Miskiyat Kamal) and (David, Naomi, and Loretta Benson) who continue to be a source of strength and inspiration to us.

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ABSTRACT

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Healthcare is an essential aspect of every human life. Every human is entitled to the right to care and must be able to access it to prevent the spread of infections and/ or cure an illness. To deliver care, healthcare professionals must have proficient medical knowledge, but also understanding of patients' health needs. Understanding patients' needs involves communication, but also the awareness of patients' thoughts and behaviors that might affect the way they receive healthcare. Mental healthcare is one of the priority health conditions of migrants, specifically Central American migrants. Additionally, Central Americans are amongst the new wave of immigrants coming into the United States.

Considering the number of Central American immigrants that reside in Houston, Texas, the purpose of this study was to understand what is being done in Houston to provide culturally competent mental health service to this population. In addition to reviewing the literature, we scanned the websites of organizations that offer mental health services in Houston and Los Angeles as a comparison group. Our findings indicate that though Central Americans do not often use mental healthcare because of them attributing it to physical pain, there is lack of adequate providers in Houston to serve this population. In addition, there is not enough research on this population because of being classified into a monolith group as Hispanic/Latino.

KEY WORDS: Cultural competence, Migration, Central American migrants, Healthcare.

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PREFACE

After taking a U.S healthcare system and Multicultural health course, we realized that there are many aspects to cultural competency in healthcare beyond language and race. The disparities that minority populations face in healthcare were emphasized in these courses; this made us develop a strong interest in learning more about the cause of these disparities. We became interested in this thesis topic when Kismot Kamal the co-author took an honors dialogue seminar on immigration, race, and global migration. During the global migration seminar, she gained ample knowledge on the concept of migration, which inspired her to the research project, "Immigration, The Corrosive Side Effects." After she met with Dr. Bilsing in the Fall of 2021, she decided to develop her research to present it at the Undergraduate Research Symposium. Kismot felt there was something missing in the research and quickly realized as a health student, the health effects of migration are rarely part of the curriculum. This ignited a curiosity to find out how the migrant population accessed healthcare services.

We chose Professor Alexander and Dr. Bouamer to be our thesis directors as they both have individual knowledge about different parts of the topic, cultural competence, and the migrant population. Professor Alexander has a broad public health knowledge in cultural competence and has also worked with underserved populations outside the United States. Dr. Bouamer is one of the professors who taught one of the honors seminars as mentioned above, and her insights and perspective about migrants are unique. Kismot Kamal has also previously worked with Dr. Bouamer on a presentation about migrant identities for the Annual Diversity Leadership Conference. During our research, we realized we were limited in time and resources, so we devised our research by narrowing down the topic to focus on the cultural competency of the provision of mental health services to Central American migrants residing in Houston.

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CHAPTER I

Introduction

Arguably, delving into the scope of cultural competence without first addressing culture is deficient. By definition, "culture is said to be the cumulative deposit of knowledge acquired by a group of people over the course of generations" (Nair & Adetayo, 2019, p. 2). It is also said to be the shared patterns of behavior and interactions through socialization (Penn State Extension, 2020). Supplementarily, cultural competence is the ability to effectively collaborate with people from different cultures; it is also a series of consistent behaviors, policies and attitudes grouped together in an agency or amongst professionals to help them to function effectively in cross cultural situations (Cross et al., 1989). As Cross et al. mentions, the phrase cultural competence derives from the word "culture," which is the pattern of human behavior that includes thoughts, actions, and beliefs. Competence suggests the "capacity to function effectively" (Cross et al., 1989, p. 13). Cultural competence is important in different fields of study such as psychology, government, and education. In the medical field, several studies show that cultural competency enhances patients' experience and outcomes (Nair & Adetayo, 2019). Cultural competency is a set of interpersonal skills that allows health care professionals to understand and acknowledge people of diverse backgrounds and supply a culturally competent service (Rice & Harris, 2021).

More specifically, culturally competent care is defined as the "ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients" (Health Policy Institute, n.d., para. 1). Culturally competent care can lead to improved health outcomes when it has been established that health disparities exist within ethnic minorities. For example, before the COVID- 19 pandemic, ethnic minority groups faced disparities in health and though there have been improvements, some disparities persist, which includes

prevalence in health conditions, infant mortality, and mental health. (Ndugga & Artiga, 2021). The pandemic has brought to light the racial injustice and inequality that continues to affect racial and ethnic groups in the United States; it has highlighted how the virus has unequally affected ethnic minority groups putting them at greater risks. (Centers for Disease Control and Prevention [CDC], 2021b). Some of the factors that contribute to these risks include education, socioeconomic status, and healthcare access (CDC, 2021b). Culturally competent care is especially important in the United States because of the huge diversity and the influx of migrant populations. Before looking into the issues at play, it is essential to introduce important definitions and concepts that will be useful for our study.

Overview of Key Definitions

Migration

In the context of migration, there are different key concepts that need to be defined to understand this dynamic and the different statuses of migrants. In general, a migrant is a person who moves away from his/her/their place of usual residence (country of origin), whether within a country or across an international border (country of destination), temporarily or permanently, and for a variety of reasons (International Organization for Migration, n.d.). The term migrant includes several legal categories including and defined by the International Organization for Migration (n.d.) as:

- **International students:** Individuals deciding to pursue their studies in a different country.
- **Migrant workers:** Individuals who usually do not decide to stay permanently. They are moving within their home country or outside to pursue work.

- **Refugees:** People who have been forced to leave their home country due to persecution, war, natural catastrophe, violence, race, religion, or political opinion and are unable to return to home due to fear.
- **Asylum seekers:** Refugees upon entering a country of destination can declare to be asylum seekers. An asylee is a person who left their country of origin as a political refugee and seeks international protection. An asylum seeker can end up becoming a legal permanent resident who is an individual who moves from their native country into a new country permanently.

Immigrants leave their countries or regions due to a variety of reasons including but not limited to the following factors: employment opportunities, to escape violence, and environmental factors such as natural disasters.

Migration in the U.S: Socio-historical and data overview

The United States has the largest foreign-born population than any other country in the world; the country accounts for one-fifth of the world's migrants (Budiman, 2020). The United States' immigration system works through different ways including reunification of families, diversity promotion, refugee protection, and skilled laborers who are valuable to the U.S economy (American Immigration Council, 2021).

Under the family-based immigration, U.S. citizens and lawful permanent residents (LPR) can bring certain family members to the United States. LPRs are usually gained through family reunification, employment-based reference, which falls under the context of a skilled laborer, refugee program for people outside the United States, an asylum program for those inside the United States, and people from countries who have relatively low levels of immigration under the Diversity Immigrant Visa Program (Department of Homeland Security, 2021). Other forms of U.S.

immigration fall under the nonimmigrant class status, which includes temporary workers and their families, students and exchange visitors, diplomats, tourists, temporary business visit, transit aliens, commuter students who are Canadian or Mexican national, alien fiancé(e) of US citizens and children, crew members, victim of human trafficking and their dependents, and victim of criminal activity and their dependents (Department of Homeland Security, 2021).

According to the Department of Homeland Security, refugees are required to apply for LPR status one year after being admitted and asylees can apply one year after they have been granted asylum (Department of Homeland Security, 2021). These are all considered legal or authorized forms of immigration to the United States. Currently about 77% of immigrants in the United States are in the country legally while about 25% are unauthorized (Budiman, 2020). In 2018, 25% of U.S immigrant population came from Mexico while the next largest groups were from China, India, Philippines, and El Salvador, a country in Central America (Budiman, 2020). The number of immigrants coming into the United States increases each year. It is estimated that about 15% of the 11.3 million unauthorized immigrants coming in are from Central America (Babich & Batalova, 2021). The inflow of Central American immigrants in the United States grew from 354,000 to over three million in 2019 (Babich & Batalova, 2021).

Central America is the southernmost region of North America and between Mexico and South America; the countries in this region include El Salvador, Guatemala, Honduras, Nicaragua, Panama, Costa Rica, and Belize. The U.S. is the top destination for Central Americans and about one third of these immigrants are naturalized U.S. citizens. The main way these Central Americans received LPR status was through family reunification (Babich & Batalova, 2021). Almost half of these immigrants live in California, Texas, and Florida (Babich & Batalova, 2021). El Salvador, Guatemala, and Honduras are known as the northern triangle countries, which is where most

Central American migrants in the U.S. are from (Babich & Batalova, 2021). Some of the push factors driving Central American migrants include violence, corrupt government, and the desire to reunite with family members who had emigrated earlier. Other factors include economic instability that persisted after the regional civil wars, Hurricane Mitch in 1998, the earthquakes in 2001, and the recent November 2020 Hurricanes Eta and Iota that destroyed the region. In addition, gang violence and the high homicide rate continue to plague this region (Babich & Batalova, 2021).

More than half of Central American immigrants live in New York, Washington, and Florida, but the largest percent are concentrated in California and Texas Babich & Batalova, 2021). According to Migration Policy, about seven percent of Central Americans live in Houston, which is said to be the most diverse city in the United States (Babich & Batalova, 2021). The city of Houston is home to over one million immigrants with unauthorized immigrants accounting for almost 30% of the population. Most of these unauthorized immigrants are identified as Central Americans and Mexicans (Capps & Soto, 2018).

The different background and statuses of immigrants, as aforementioned, might have contrasting effects in the acculturation and assimilation process in their destination country (Schwartz et al., 2010). Schwartz and other scholars seek to broaden the scope of scholarship on acculturation and how it is related to psychosocial and health outcomes. We define these two concepts below.

Acculturation

Acculturation unfolds in four different dimensions: marginalization, separation, assimilation, and integration (biculturalism). A better understanding of terms like acculturation and assimilation is crucial. According to Schwartz, acculturation refers to changes that take place because of contact with culturally dissimilar people, groups, and social influences. While it can be

examined locally, it is mainly studied in individuals living in countries or regions other than where they were born (Schwartz et al., 2010). Respectively, marginalization occurs when an immigrant does not identify with their cultural heritage nor with the new culture, and this is considered a rare case. Separation is an acculturation strategy adopted when an immigrant places high value on their cultural heritage and refuses to learn about the new culture. Assimilation is a situation whereby immigrants reject their culture of origin (willingly or unwillingly) and fully identify with the new dominant culture. Lastly, integration (biculturalism) is adopted when immigrants are successful in maintaining their cultural heritage and interacting with the new culture. This, according to Schwartz, is suggested to be the best form of acculturation as it yields the best psychological and health outcomes amongst all four models due to a balanced integration of their heritage and accepted culture. For example, there seems to be better results in terms of improved self-esteem, improved family relationships, and reduced depression and anxiety (Schwartz et al., 2010).

While the definition of acculturation appears simple, the acculturation process in practice is complex. According to Schwartz, there are numerous factors that can affect the degree of cultural adaptation changes that immigrant may face. It can first depend on the age at the time of arrival. Young children who migrated in their first few years of life have been proposed to facilitate the transition to adopting the cultural customs, values, and identities of the host country easily compared to migrants of older age groups. These types of migrants are referred to as the 1.5 generations and are notably like, what Schwartz calls the second-generation migrants, which we will refer to as children of immigrants due to the problematic implications of such categorization (Schwartz et al., 2010). Secondly, adult migrants tend to vividly remember their lives before migration, and thus have difficulty or reluctance to accept the values, customs, and identities of the host country (Schwartz et al., 2010).

Thirdly, acculturation is said to be an issue faced by some and not all. As a result, migration-related issues such as pre- and post-migration traumas, lack of documentation, and language barriers will not apply to the children of immigrants born and raised in their parents' country of settlement (Schwartz et al., 2010). Moreover, these children of immigrants are less likely to face the same type of discrimination experienced by their parents. However, they are still likely to experience microaggressions and other discrimination. Microaggressions are broadly defined as behaviors that obscurely neutralize a minority. This is a short, subtle verbal and/or non-verbal defamatory message, often targeted at a minority and/or race that carries the weight of the latent bias of an aggressor under their conscious interest (Cruz & Mastropaolo, 2019). For example, some Hispanic and Asian Americans are asked "where are you *really* from?" despite English being their first language. This question suggests that they are still somehow not fully American because of their ethnic backgrounds (Schwartz et al., 2010).

Finally, the preservation of cultural heritage may unfold in ethnic settlements differently than in other types of contexts, as it is assumed to be important for older migrants living in "ethnic enclaves." Ethnic enclaves are areas or neighborhoods where most residents are from the same ethnic group. Examples are Miami, the South Bronx, East Los Angeles, and the illustrious "China town" neighborhood in various U.S. cities. It is assumed that cultural heritage and traditions are preserved in these enclaves so that older immigrants who have not received formal education in the settled country can function effectively in their daily activities without interacting with the practices and social values of the host culture. The existence of an influential cultural community legacy can encourage children of immigrants and future generations to embrace and preserve the original cultural heritage (Schwartz et al., 2010).

An educational question has been raised as to whether assimilation is related to forced acculturation, which Schwartz and other scholars referred to in their past work as the "Immigrant Paradox." This concept is manifested in multiple ways. One way is that assimilated children of immigrants might face worse developmental outcomes than their non or less assimilated peers (García Coll & Marks, 2012). Seeing that assimilation falls under this context, we wondered if immigrants succumb to one or more of the four models of acculturation to function in their new host country. According to Schwartz and his co-authors, during and after World War I, Polish, Italian, and Jewish immigrants faced discrimination by an openly hostile administration chaired by President Theodore Roosevelt and 'in the assimilation' labeled as 'inappropriate', forced German immigrants to learn English (Schwartz et al., 2010); subsequentially, the children of this wave of immigrants were particularly like other Americans in appearance and tone. They increase the negative consequences of cultural adaptation for other immigrants because they primarily ignore the ethnic and cultural values and heritage of their parents.

In particular, the "new wave" of immigrants from non-European countries like Central Americans assume that they must accept the designated ethnicity like the category of Hispanic/Latino in their host country (USA) (Schwartz et al., 2010). Countries of origin, such as China, India, and other Asian countries, can suddenly be grouped into minority ethnic groups in the host country (Schwartz et al., 2010). Another situation is the "Hispanic" ethnic category, which is designed to classify individuals from Spanish-speaking Latin America as one monolith group in America, which is not common in Latin America. As a result, when new immigrants enter these countries, they face challenges integrating into the host society. They accept these labels from the host country as a coping mechanism to avoid unfair stereotypes faced by immigrants in the region,

such as prejudices related to recognizable foreign accents or inability to speak the language of the host country (Schwartz et al., 2010).

Thesis and **Research Questions/Interests**

Many immigrants unauthorized or authorized might face post-migration issues that include mental health trauma, deportation, and acculturation (Médecins Sans Frontières (MSF), 2021). Looking at the stories in the article shared by MSF (Doctors without Borders), it is evident that most migrants who are coming from Central America are escaping violence from their home countries. Most of these migrants walk thousands of miles to get to the United States to either end up getting deported or stranded in Mexico or a displacement camp (National Immigration Forum, 2019). This is one of the reasons why it is of utmost importance to consider the mental health of Central American migrants.

According to the CDC, when providers care for Central Americans, they need to look at five different priority health conditions. These include anemia, Chagas disease, mental health issues, obesity, and soil-transmitted helminth infections (CDC, 2021a). The stories of Central American migrants inspired us to think about the mental health of Central Americans. We asked whether or not they are getting appropriate mental healthcare. We also investigated the conditions of such care. For example, Doctors Without Border shares the story of a migrant from Guatemala who explains "I am from the Yuki Yuna indigenous community. I left my country because I was raped by three men, and because of poverty in my community and also because I no longer have a home with my parents" (MSF, 2021, para. 2). It is important to consider personal stories since there is limited research focused on Central Americans and their mental health. Most of these background stories like deportation issues and some of the effects of migration process could help

providers in terms of providing culturally competent mental healthcare to migrants coming from Central America.

Most times migrants from these countries are categorized in broader terms like Hispanic/Latino or farmworkers. The broad categorization does not truly represent the diversity and specificities/particularities of national origin (Organista & Ngo, 2019). As this population is increasing in the United States, it is important for mental health professionals to know and understand the specific background of Central American immigrants to be able to provide culturally competent mental health services. Regrettably, there is a huge disparity in research in regard to culturally competent mental healthcare services (Nair & Adetayo, 2019).

Considering the number of Central American immigrants that reside in Houston and the reasons for their migration and how this might impact their health, we want to understand what is being done in Houston to provide culturally competent mental health services to Central American migrants. In the section that follows we highlight some of the most relevant research on the process of migration and the provision of culturally competent mental health services to Central American migrants.

CHAPTER II
Literature Review

Post-Migration & Acculturation Issues

Some of the underlying issues with mental health amongst migrants are acculturation as well as emotional and behavioral symptoms post migration. The recent migrants from Central America are mostly women and children, specifically youths (Walker et al., 2021). Acculturation is said to have a detrimental after-effect on immigrants. Mengistu and Manolova state that literature on acculturation and mental health amongst forced migrants varies on a case-by-case basis as it is overly complex and often inconsistent due to the unique experience of each migrant based on age, social settings, and other determining factors (Mengistu & Manolova, 2019). It is suggested that acculturation has a negative effect, and it is associated with worse physical, behavioral, and mental health outcomes or perceptions such as self-esteem, distress, drug and alcohol use and chronic disease (Schwartz et al., 2010). Studies have shown that higher rates of acculturation are associated with problematic health outcomes, a phenomenon known as the immigration paradox (Schwartz et al., 2010). As mentioned earlier, there are different contexts of cultural adaptation that include assimilation, which is closer to the negative side of the context and leads to the paradox of immigrants.

There are also several mental health problems that could develop from this experience alongside the trauma from their home countries, family separation, and migration process (Walker et al., 2021). Furthermore, migration related trauma can be associated with different mental health illnesses particularly "separation anxiety" (Walker et al., 2021). Many migrants continue to migrate to the United States in hopes of receiving asylum protection. However, the Department of Justice has asked to prosecute those crossing the border illegally including asylum seekers (Bucay-Harari et al., 2020). Mothers who are separated from their

children suffer from anxiety, stress, and depressive symptoms due to this process (Walker et al., 2021.) In the U.S., there is a lack of knowledge of the host country's health system amongst migrants. This poses a barrier to the health services they get and language/cultural challenges alongside limited health services access due to their illegal status (Suphanchaimat et al., 2015). Forced acculturation, family separations, and post migration settlements impact the mental health of migrants. In addition, most Central American immigrants are low income or/and seeking asylum, so their experiences fit the context of forced migrants.

Cultural Competence & Mental Health Care

Literature acknowledges the fact that mental health usage in the United States is incredibly low especially among underrepresented minority communities. Rice and Harris point out that there is evidence lacking in the development of culturally competent guidelines; although, the American Psychological Association (APA) and Association for Multicultural Counseling and Development recognizes the importance of cultural competence in providing mental healthcare (Rice & Harris, 2021). The need for cultural competence in the U.S. healthcare system within minority communities is essential because of the many diverse cultures grouped into one ethnicity.

There are also different characteristics of cultural competence; cultural competence encompasses three domains: cultural awareness and sensitivity, knowledge, and skill (Lin et al., 2017). Each domain addresses varied factors of cultural competence. Cultural sensitivity and awareness address the importance of keeping an open mind to recognize cultural differences and to respect other cultures. Cultural knowledge addresses the need for satisfactory knowledge to enhance cultural attitudes and use resources to supply culturally sensitive care (Lin et al., 2017.) Finally, cultural skills address the necessity for case evaluation and recommend right adjustments to care. In their article, Lin et al. used several instruments that test the three domains

of cultural competence to sample healthcare professionals from different sectors such as nursing students, hospice workers, community health nurses, health education, and nursing faculties. The overall results show that cultural competence is positively associated with improved quality of care (Lin et al., 2017).

Patients of distinct cultures have diverse ways of expressing symptoms of mental illness that make it difficult to diagnose; not to mention perceived discrimination, which may also lead to decrease in use of health services (Rice & Harris, 2021). Scholars have mentioned that patients need to be educated on mental health care services and information supplied should highlight the importance of seeking treatment (Rice & Harris, 2021). Some of the identified problematic issues pertaining to cultural competence are lack of exposure and inadequate education and curriculum related to diversity (Nair & Adetayo, 2019). Finally, the lack of cultural competence training among health care professionals is said to be one of the reasons for the low use of mental health resources. Articles have continually shown that within the healthcare system in the United States, there are people who cannot access mental health services (Rice & Harris, 2021). This may also mean that it will be much harder for migrants to access these services.

Mental Health Needs & Service Utilization

There are stressors and barriers to immigrants' experience in a new country that might have an impact on their mental health. Comparing Census Bureau's data on population from 2003 to 2014, they now project an increase in Hispanic immigrant populations in the United States by 57% (Krogstad, 2014). While there are several studies on the Hispanic population, it is important to recognize that this specific population is not a monolith group. There are significant differences amongst this population that make their background and culture unique (Bucay-Harari et al.,

2020). It is hard to find how and why Central American immigrants do not use mental healthcare services even when they need it because they are categorized as Latinos in one group (Krogstad, 2014). This is one of the assumed reasons why it is hard to find research on Central American immigrant population in the United States. While there are articles that mention Central American immigrants, they did not identify the issues amongst these populations that is depriving them of mental health services (Rosales & Calvo, 2019.) Some literature focuses on Hispanics and address immigrants but do not specify if immigrants are being offered mental health services.

A study was done on Hispanic immigrants living in Arkansas, United States, and the rate at which they use mental healthcare. Eighty-four adult participants who were living in Arkansas both from South and Central America participated in a diagnostic interview and a service use interview with trained bilingual research assistants (Bridges et al., 2012). Results showed that although 42% of the sample saw a physician the year before, most of them saw religious leaders for mental health services. This shows that there is a need for mental healthcare amongst this population. However, they are mostly seeking mental health care, specifically symptoms, signs, and ill-defined conditions (SSIDC) because of physical pain not because they understand the psychological need (Bucay-Harari et al., 2020).

Understanding the qualities of organizations providing mental health services to the Hispanic population might help reduce the systemic inequalities (Rosales & Calvo, 2019). Rosales and Calvo used the national mental health service survey and data to measure the utilization of mental healthcare services amongst Hispanics and the organizations providing these services. The results showed about 63% of healthcare organizations focus on the provision of mental healthcare (Rosales & Calvo, 2019). However, these services were not being used. The most common barriers to the utilization of healthcare are

cost, lack of health insurance, and language (Bridges et al., 2012). More importantly, when talking about the Central American population, understanding the migrant background and culture is significant. The disparity of health services for migrants, as explained by Suphanchaimat et al., is concerning; diverse cultural beliefs, language differences, limited institutional capacity, and limited labor are the key factors in the provision of efficient culturally sensitive care to migrants (Suphanchaimat et al., 2015). Like Suphanchaimat et al. mentioned in their article, the difficulties of overcoming language barriers were not solved by hiring interpreters; therefore, health care providers would have to identify if services fit the needs of patients (Suphanchaimat et al., 2015). Some of the findings like migrant patients seeing a doctor only when they feel physical pain and the barriers to the use of mental health services such as cultural beliefs and language are still the problems with health quality today.

Restating Thesis Question

As aforementioned, Houston is the focus of our research because it is amongst the top five cities where most Central Americans live (with Los Angeles coming first). We wondered what is being done to provide culturally competent mental health services to Central American migrants.

CHAPTER III

Methodology

To see what is being done in Houston in terms of the provision of culturally competent mental health care to Central American immigrants, we reviewed and scanned mental health organizations' websites. We started with a literature review; we specifically looked at publications that are less than 10 years old and searched key words like systematic, meta narrative or meta-analysis, cultural competence, mental health, Hispanic, and Latino. We looked at several publications using the National Library of Medicine and Research Gate. However, only 11 was useful for our research and review. The 11 publications were selected in terms of criteria; if they mentioned cultural competence of mental health providers and if they mentioned Hispanic population or/and Central Americans. The literature review was useful as we were able to learn of what research has been done on Central American migrants specifically, and if it has anything to do with mental health services and culturally competent care.

For the websites, we scanned through the migration policy website to gauge the number of Central American immigrants currently in Los Angeles, California and Houston, Texas. Through convenient sampling, we got a list of organizations in the Houston area and by surfing the Internet we got another list of organizations for Los Angeles. Five mental health organization websites were scanned in each city, but two from each city were used for comparison. The criteria for each website selected out of ten included: if the organization provides mental health services, if they incorporate Spanish language, if they mention cultural competence or sensitivity, if their website is easy to navigate in terms of information, and if they mention migrants.

Thereafter, we looked through the county health rankings and identified the number of mental health providers in Harris and Los Angeles counties. Overall, through convenient sampling and Internet surfing, we were able to find some public information that signifies if migrant populations, specifically Central American immigrants, are being provided culturally competent mental health care.

CHAPTER IV

Results

Ratio of Population to Mental Health Providers (Comparing Two cities with most Central American Immigrants)

To speak on cultural competence in mental health care, it is important to know if there are any providers currently providing care for Central American immigrants in the United States and specifically in Houston, Texas. Thus, looking at the number of mental health providers available to Central American immigrants is important to bridge the gap of research for this population. An important fact to know is that Los Angeles has the highest population of Central American immigrants in the U.S., (Babich & Batalova, 2021) which is why looking at data in Los Angeles compared to Houston is best.

According to Migration Policy, Houston and Los Angeles are among the top five cities with the most Central American immigrant populations with Houston housing over 200,000 Central American immigrants and Los Angeles over 500,000 (Babich & Batalova, 2021). The total population of people in Los Angeles is about 10,039,107 compared to Houston with a little over 2 million (Census Bureau, 2019). Looking at the county health rankings, there are more mental health providers in Los Angeles than in Houston (County Health Rankings & Roadmaps, 2021). Los Angeles has 36,404 providers, which is more compared to other counties in the state of California while Houston has only 5,889 mental health providers. See Table A below with a comparison of Houston to Los Angeles in terms of population and number of mental health providers. The ratio of population to mental health providers in Harris County (in which Houston resides) is 800:1 and in Los Angeles County it is 280:1 (County Health Rankings

& Roadmaps, 2021). With less providers for the general population in Houston, there might not be enough providers geared towards Central American adult migrants.

Table 1

Number of Total population & Central American Immigrant Population Compared to Number of Mental Health Providers

City	Total Population	Central American Immigrant Population	Number of Mental Health Providers
Houston	2,304,580	251,000	5,889
Los Angeles	10,039,107	565,000	36,404

Note: Adapted from "County Health Rankings" and "Census Bureau Quick facts" by County Health Rankings & Roadmaps (2021) https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/clinical-care/access-to-care/mental-health-providers Copyright 2021 County Health Rankings. By Census Bureau. (2019). *QuickFacts: Houston city, Texas; Los Angeles County, California; California.* (Infographic) https://www.census.gov/quickfacts/fact/table/houstoncitytexas,losangelescountycalifornia,CA/PST045219

Websites Scanning

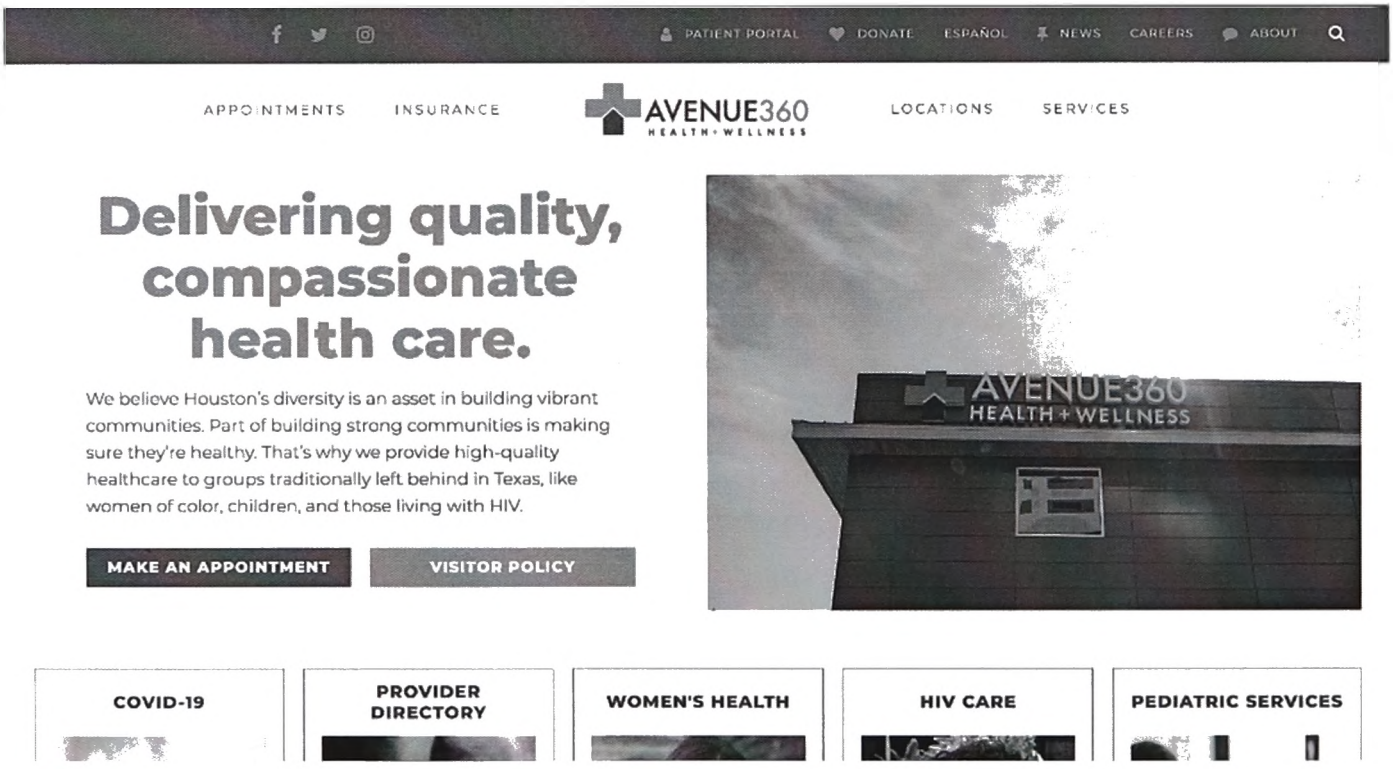
After scanning websites of different mental health organizations in Houston and Los Angeles, two organizations in the cities appeared to fit the standard of organizations that will serve migrant populations, specifically Central American migrants. The other websites were scanned out because they either only offer services in English, their websites were difficult to navigate due to too much information, or to the fact that their services do not cater to migrant populations.

In Houston, Avenue 360 Health and Wellness is a federally funded non-profit organization that provides primary, dental, and behavioral medical care to underserved populations (Avenue 360, 2020). Their mission is to provide and promote quality care in the community (Avenue 360, 2020).

Avenue 360's website is fairly easy to navigate in terms of accessibility via mobile phone and clear information on the type of services they offer. They have an option to view the website in Spanish directly at the top tab which suggests that they serve Spanish speaking populations. The website also indicates the provision of housing for underserved populations, which will be helpful for migrant population coming into Houston. The most important aspect is access; the website does not seem to indicate opening hours but does have a 24-hour call line specifically for behavioral health service. A picture of the homepage is shown in Figure 1 below.

Figure 1

Avenue 360 Health and Wellness Homepage



Note: there are images with indication by text that describe what services they offer from "Avenue 360 Health and Wellness" by Avenue 360. (2020). *About.* https://avenue360.org/about-2/ Copyright 2021 Avenue 360 Health & Wellness.

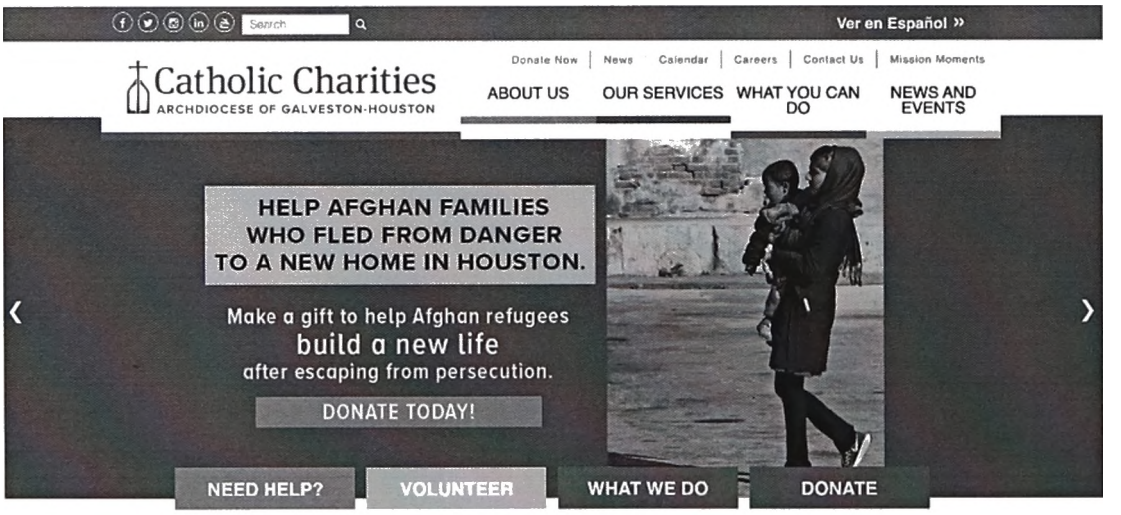
The second organization that was scanned in Houston is Catholic Charities Houston. This is a faith based non-profit organization whose mission is guided by God's love in helping and advocating for people in southeast Texas in collaboration with parishes and communities (Catholic Charities of the Archdiocese of Galveston-Houston, 2021). Catholic Charities Houston has multiple locations around Houston.

It is hard to navigate their website as there is too much information at once and their services are not clearly identified on a mobile phone. An important thing to note is

that this organization provides legal immigration and refugee services and offers interpreter services over the phone, but their website cannot be navigated in Spanish. Their head office is open Monday to Friday from 8am to 5pm and they have 24-hour helpline available seven days a week. However, they do not accept in person appointments or walk-ins. A picture of the homepage is shown in Figure 2 below.

Figure 2

Catholic Charities Archdiocese of Galveston- Houston Homepage



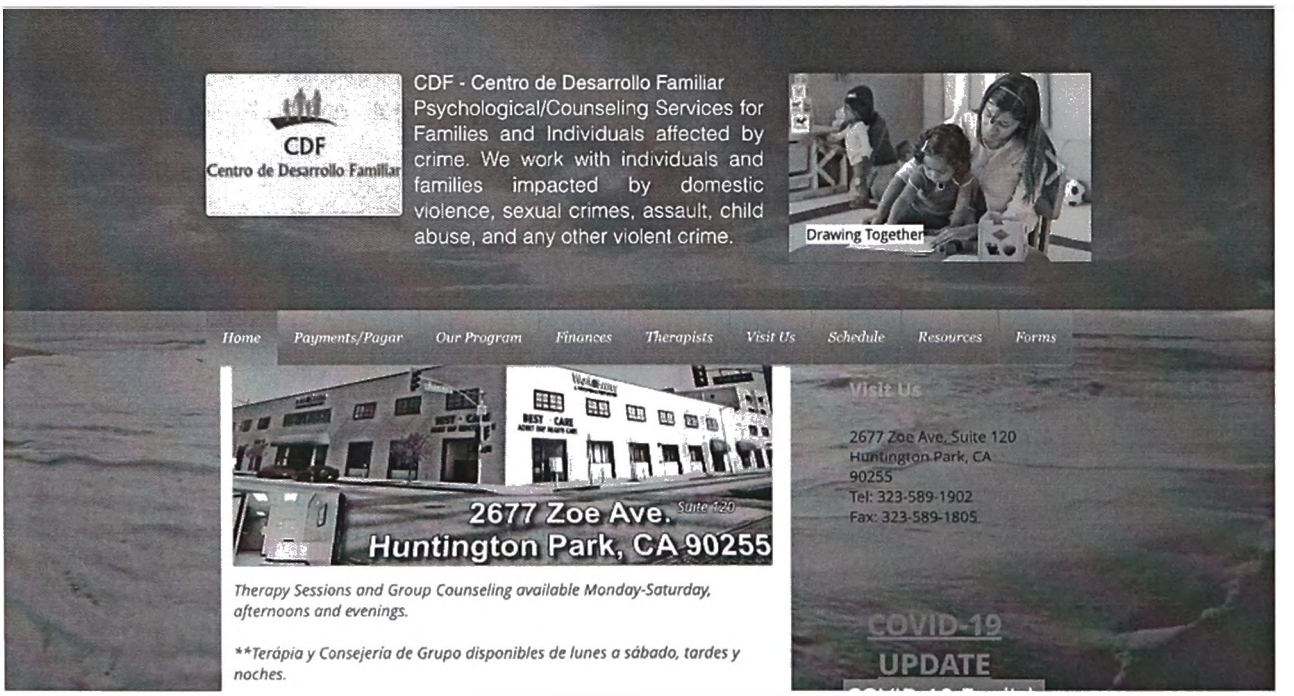
You Can Help Afghan Families Build a New Life.

Note: The webpage has an option to view in Spanish and their text are bolded and clear from "Catholic Charities of the Archdiocese of Galveston – Houston" by Catholic Charities of the Archdiocese of Galveston-Houston. (2021). *Homepage*. https://catholiccharities.org/

In Los Angeles, the two organizations scanned include Centro de Desarrollo Familiar which translates to "The Center of Family Development" and Long Beach Comprehensive Health Center. Centro de Desarrollo Familiar mentions on their website that they offer a culturally and linguistically competent service to their patients. It is in Los Angeles with over four decades of operations (Centro de Desarrollo Familiar, n.d.). It is a for profit organization as they charge a low-cost fee, ranging from $25-$125 depending on the program, which is due at the time of visit. They do not have a mission statement, but their history states that they provide counseling services to victims of sexual assault, child abuse, violent crimes, and domestic violence. Centro de Desarrollo Familiar's website is fairly easy to navigate as it is written in both English and Spanish and is accessible via mobile phone. According to the website, therapists are available by appointment on Monday-Saturday and at different times (Centro de Desarrollo Familiar, n.d.). A picture of the homepage is shown in Figure 3 below.

Figure 3

Centro de Desarrollo Familiar Homepage



Note: The webpage shows information both in Spanish and English and a bold text of their address. From "Centro de Desarrollo Familiar" by Centro de Desarrollo Familiar. (2015). *homepage*. https://www.cdf-centro.com/ Copyright 2023 by Natural Remedies.

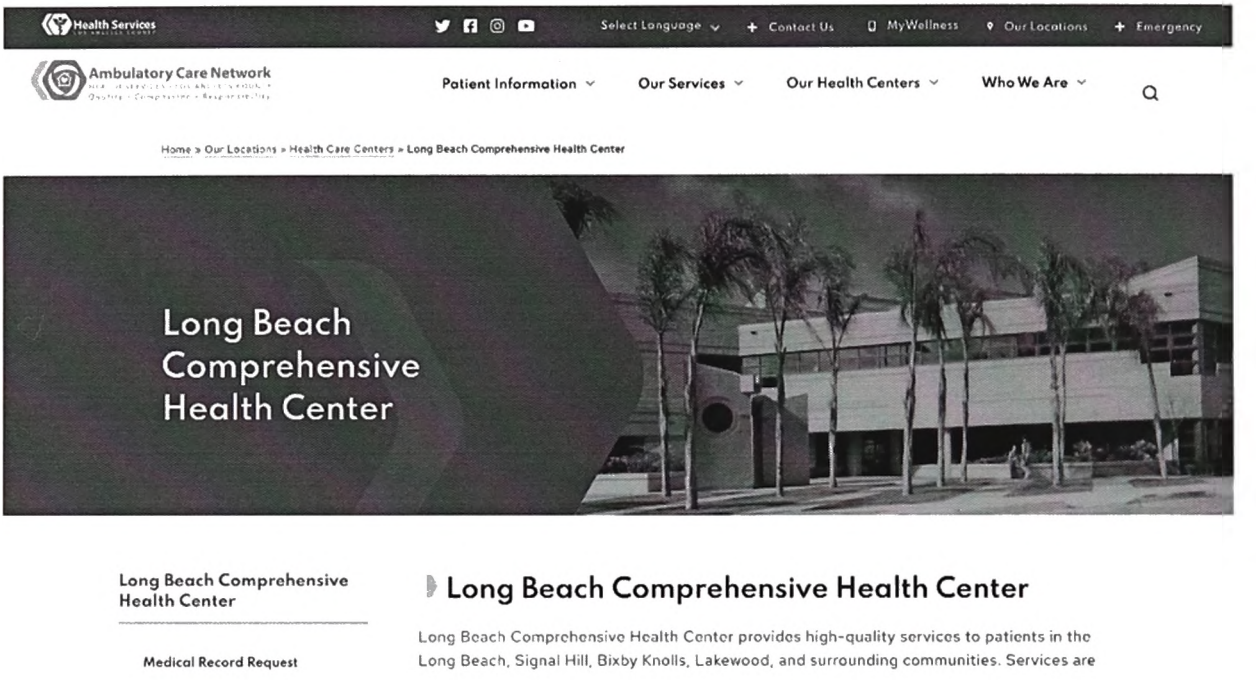
Long Beach Comprehensive Health Center, according to their website, is a culturally sensitive organization that provides high-quality primary care and mental health services in partnership with their sister's facility "Los Angeles County Department of Mental Health" (LACDMH) for adults, families, children, and women in a patient-centered medical home model in the Long Beach and surrounding communities.

The website does not indicate whether it is nonprofit or for profit. However, it caters to low-income patients, and it is committed to reaching every patient with adequate and quality care. This is visible as its financial service staff are available to help low-income patients apply for financial programs such as but not limited to the Medi-Cal and LA County No-Cost/Low-Cost programs (Long Beach Comprehensive Health Center, 2020).

This organization mentions that they effectively cater to migrants in a culturally competent manner by providing services in multiple languages such as (English, Spanish, Tagalog, Farsi, and more upon request) at no cost to patients. The website looks organized and easy to navigate in terms of mobile phone accessibility and clarity of information. Their hours of operation are Monday through Friday between 8:00am – 4: 00pm. A picture of the homepage is shown in Figure 4 below.

Figure 4

Long Beach Comprehensive Center Homepage



Note: this is to show an overview of what the organization's website looks like from "Long Beach Comprehensive Center" by Health Services Los Angeles County. (2020). *Long Beach Comprehensive Health Center* https://dhs.lacounty.gov/longbeach/

Additionally, Table 2 shows a list of services, languages, and hours for each of the four websites.

Table 2

Infographic of services, language, and hours for scanned mental health organizations

Name	**Location**	**Services**	**Languages**	**Hours**
Avenue 360 Health and Wellness	Houston	• Primary, dental, and behavioral medical care to underserved populations	Spanish English	No indication of opening hours; 24-hour helpline.
Catholic Charities of the Archdiocese of Galveston-Houston	Houston	• Food Distribution • Family Assistance • Counseling and Behavioral health • Legal Immigration and refugee services	English	M-F 8am to 5pm plus 24-hour helpline available 7 days a week
Centro de Desarrollo Familiar	Los Angeles	• Primary care • Counseling services • Rehabilitation services	Spanish English	M/W 9am 6pm T/Th 9am-5pm Friday 9am-4pm Saturday 10am-2pm
Long Beach Comprehensive Health Center	Los Angeles	• Primary care • Radiology • Laboratory, and social work • Mental health services	English Spanish Tagalog Farsi	M-F 8am-4pm

CHAPTER V

Discussion

Based on what we have researched so far, we can assume that there is a need for cultural competence training in mental healthcare and within healthcare organizations at large. The focus of this research is to see if culturally competent mental healthcare services is being provided to Central American migrants in the Houston, Texas area. Whenever people hear about migrants specifically categorized as Hispanic/Latino, they are quick to assume that they are Mexicans. Especially, because many migrants from Central America go through the U.S - Mexico border. We believe this assumption is one of the reasons why it is hard to find research on Central American migrants. Some of the barriers to the provision of mental healthcare to Central Americans is not only limited to lack of research on the population, but also issues of immigration law, acculturation, low utilization of mental health services, and cultural competence.

We found that the gap in research on this population is also tied to the level of cultural competence in mental healthcare providers. In Houston, there is not enough mental health providers to begin with, which likely means there is a low chance of migrants, specifically Central American migrants, getting the mental healthcare that they need. Also, it seems that organizations that provide mental health services in the Houston area are geared towards services rather than people. Whereas, in comparison, the websites we consulted in Los Angeles mention that their services include culturally sensitive and linguistic service. While scanning the organizations' website, specifically in Houston, we found that some organizations do not have a Spanish language option on their website. For example, we ended up including Catholic Charities Houston as one of the comparisons because of the type of services they offer are geared towards migrants, and they

mention offering phone interpreter services. While this is useful, Central American migrants might not be able to view this information as the website cannot be navigated in Spanish. We also included this organization because of the faith-based aspect. According to Pew Research, about half of the population in Central America are Catholic (Pew Research Center, 2014). Therefore, it is likely that most Central American migrants will gravitate towards this organization because of faith relations.

Another mental health organization in Los Angeles, Centro Desarrollo Familiar, has a website that is easy to navigate in Spanish, but their hours of operation are different for every weekday, which might not be accommodating for their target patients. The point of the organization scanning is to see if there are any health organizations that provide mental health services to migrants and if Central Americans can access these services easily through these websites. The cultural competence aspect is for healthcare professionals to understand that there are different forms of cultural competence that go beyond just language, but includes understanding of patient's cultural background, and the right cultural skill to collect relevant cultural data specific to each patient. Through this research, we found that healthcare professionals do not need to know everything about a patient's culture to be culturally competent. However, they need to be informed and consider some of the cultural differences of patients and how it can influence how they provide care for each patient.

Suggestively, it is critical to address these gaps and disparities in healthcare effectively, and notably, some measures have been adopted to attain cultural competence via targeting upper-level executives to identify cultural competency as a high priority because unfortunately, it is not a priority in an "overloaded academic curriculum" (Nair & Adetayo, 2019). According to research, a review of cultural literacy health care systems identified five interventions to improve cultural

competence: (1) gear programs to recruit and retain diverse staff members, (2) cultural competency training for healthcare providers, (3) use of interpreter services to ensure individuals from different backgrounds can effectively communicate, (4) culturally appropriate health education materials to inform staff of different cultural backgrounds, and (5) provision of culturally specific healthcare settings (Nair & Adetayo, 2019). Cultural competence can be improved by incorporating interventions such as health promotion, health education, and awareness.

A study was conducted amongst 119 California hospitals, and it revealed that non-profit hospitals serve more diverse patient populations and are more affluent and competitive in the healthcare market. It also states that they exhibit higher cultural competency. Thus, an educational argument can be made that giving market incentives for implementing culturally competent programs can enhance the delivery of culturally competent services in hospitals. For example, if culturally competent health services is linked to better patient experiences and outcomes and hospitals are rewarded for positive patient outcomes, then hospitals are more likely prompt organizations to aim for cultural competence (Nair & Adetayo, 2019).

Furthermore, if professionals in research start to specify communities within the Hispanic/Latino population, this will serve to not only fill the gap of research, but also might fulfill cultural competence beyond the linguistic aspect. Healthcare professionals are not the only people needed to be culturally competent when delivering services. Many healthcare organizations incorporate mental health services programs in their services (Rosales & Calvo, 2019). When creating these programs, it will be helpful to understand the contextual factors among different Latino groups that includes the different processes of migration, exposure to violence, and access to support groups (Bucay-Harari et al., 2020). Many minority communities do not seek mental health care because they do not trust the health care field or believe that these problems should

stay within family (Rice & Harris, 2021). Education on mental health can increase the utilization of mental health services. This can be done by providing useful and adequate information on mental illness and the common and unique symptoms to help people self-identify their mental health needs (Rice & Harris, 2021). For instance, acculturation is said to have a detrimental after effect on immigrants (Mengistu & Manolova, 2019). Psychiatrists understanding some of the root causes of the mental illness in Central American migrants will be able to provide a culturally tailored service and follow up for the patient. Due to this, patients are more likely to come back (Rice & Harris, 2021). Taking all these suggestions into account will further the improvements of cultural competence in the provision of mental health services in general.

CHAPTER VI

CONCLUSION

Some of the limitations to our research includes the lack of approval of the Institutional Review Board, as this research was done in a limited time, we could not go through a three-month process of getting approval. Therefore, we could not conduct a case study as we had proposed. The case study would have answered our question on the effectiveness of the provision of culturally competent mental healthcare services to Central American migrants. Although, the website scanning and literature review allowed us to fill part of the gap of research on this population (the geographical aspect). Overall, the results did not answer our questions on the provision of culturally competent mental health services amongst Central American migrants in Houston, but it did allow us to see what it looks like to seek mental health services through an organization's website and over the phone. We hope that this article will motivate researchers to further investigate this population and help mental health organizations realize the importance of the provision of culturally competent care to their patients in the Houston area, and in a broader context.

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APPENDIX

List of Websites Scanned out

Mental Health Organizations in Los Angeles

1. Long Beach Health and Human Services: Longbeach.gov (2019). https://www.longbeach.gov/health/healthy-living/individual/mental-health/
2. Eldorado Community Service Center: American Health Services (2021). https://www.americanhealthservices.org/newhall-california.html
3. Pacific Clinics: Pacificclinics.org (2016). *Pacific Clinics Advancing Behavioral Healthcare*. https://www.pacificclinics.org/
4. Hope Street Family Center: Hopestreetfamilycenter.org (2014). *Hope Street Family Center*. https://www.hopestreetfamilycenter.org/home/hopestreethome
5. Wesley Health Center Institute (Website not found)

Mental Health Organizations in Houston

1. Behavioral Health Care Consultant: *Welcome to Behavioral Health Consultants - Houston, Texas*. (2021). Bhchouston.com. http://www.bhchouston.com/index.html
2. Hope Clinic Community Center: *Affordable Healthcare Houston Community Clinic*. (2019). Hope Clinic Houston Multilingual Medical Services. https://www.hopechc.org/
3. Legacy Community Health: *Health Clinic in Houston TX Legacy Community Health*. (2015, July 5). Legacy Community Health. https://www.legacycommunityhealth.org/
4. Ben Taub Hospital-psychiatric Inpatient Unit: *Ben Taub Hospital*. (2021). Harrishealth.org. https://www.harrishealth.org/locations-hh/Pages/ben-taub.aspx
5. Alliance For Multicultural Community Services – The Alliance Wellness Center (page not Found)

Vitae were removed during scanning